

ELECTRONIC FUNDS TRANSFER (EFT) INFORMATION

Electronic Funds Transfer (EFT) is the **required** payment method to deposit funds for claims approved for payment. These funds can be credited to either checking or savings accounts, directly into a provider's bank account, *provided* the bank selected accepts Automated Clearing House (ACH) transactions. EFT also avoids the risks associated with mailing and handling paper checks, **ensuring funds are directly deposited into a specified account.**

The following items are specific to EFT:

- The release of direct deposits depends on the availability of funds. EFT funds are released as directed by the Alabama Medicaid Agency. The earliest date funds are available is Saturday mornings following the checkwrite.
- Pre-notification to your bank takes place following the application processing. The pre-notification process takes place over a time frame of twenty-one (21) days. Direct deposits when owed to a provider will be made according to the release guidelines in the bullet above. The Remittance Advice (RA) Report furnishes the details of individual payments made to the provider's account during the weekly cycle.
- The availability of RA reports is unaffected by EFT and they typically are received by the end of the week following the checkwrite.

HP must provide the following notification according to ACH guidelines:

"Most receiving depository financial institutions receive credit entries on the day before the effective date, and these funds are routinely made available to their depositors as of the opening of business on the effective date.

However, due to geographic factors, some receiving depository financial institutions do not receive their credit entries until the morning of the effective day and the internal records of these financial institutions will not be updated. As a result, tellers, bookkeepers, or automated teller machines (ATM) may not be aware of the deposit and the customer's withdrawal request may be refused. When this occurs, the customer or company should discuss the situation with the ACH coordinator of their institution who, in turn, should work out the best way to serve their customer's needs."

The effective date for EFT under the Alabama Medicaid Program is based on release of funds as directed by the Alabama Medicaid Agency. The earliest effective date is Saturday following the checkwrite (if funds were made available from the Agency for the particular provider).

Complete the Provider Web Portal Application Electronic Funds Transfer Authorization Agreement. **A voided check or an official letter from the bank must be submitted with the agreement.**

Submit with the bar coded cover sheet to HPES' Provider Enrollment Department at:

P O Box 241685, Montgomery, AL 36124-1685

ELECTRONIC FUNDS TRANSFER AUTHORIZATION AGREEMENT

Provider Name

Group/Payee NPI

Note: Complete all sections below and **attach a voided check or an official letter from the bank for verification purposes.**

Enter ONE group/payee NPI per form. EFT information is an enrollment requirement.

Submit with the bar coded cover sheet to HPES Provider Enrollment Department at P O Box 241685, Montgomery, AL 36124-1685.

Application Tracking Number

Provider Name

Group/Payee NPI

Payee Address

Provider Phone No.

Bank Account Information

Bank Name

ABA/Transit No.

Bank Phone No.

Account No.

Bank Address

Type Account (check one)

Checking ☐

Savings ☐

I (we) hereby authorize Alabama Medicaid Agency to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I (we) understand that I (we) am responsible for the validity of the information on this form. If the company erroneously deposits funds into my (our) account, I (we) authorize the company to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay period.

I (we) agree to comply with all certification requirements of the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by the Alabama Medicaid Agency or its fiscal agent. I (we) understand that payment claims will be from federal and state funds, and that any falsification, or concealment of material fact, may be prosecuted under federal and state laws.

I (we) will continue to maintain the confidentiality of records and other information relating to recipients in accordance with applicable state and federal laws, rules, and regulations.

Authorized Signature (Original signature required)

Date

Title

Internet Address (if applicable)

Contact Name

Phone

Input By _____ Date _____